# Dr Guindy and Partners (also known as Orchard Surgery)

## Quality Report

Orchard Surgery
Kmypersley Road
Norton In The Moors
Stoke on Trent
Staffordshire
ST6 8HY
Tel: 01952 620138
Website: www.orchardsurgery.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires improvement |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as Requires Improvement overall.** We previously inspected the service in November 2014 and rated the practice as Good overall. The practice had displayed their ratings in a prominent place within the surgery.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires Improvement

People with long-term conditions – Requires Improvement

Families, children and young people – Requires Improvement

Working age people (including those recently retired and students – Requires Improvement

People whose circumstances may make them vulnerable – Requires Improvement

People experiencing poor mental health (including people with dementia) - Requires Improvement

We carried out an announced comprehensive inspection at Dr Guindy and Partners (also known as Orchard Surgery) on 22 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had some systems in place to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice hadsome systems to keep patients safe and safeguarded from abuse.
- The systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff needed strengthening. For example, window blinds had loop cords attached to them; however there was no risk assessment in place to manage the risk to patients.
- There was a system to manage infection prevention and control and patients commented that the practice was always clean. However, there was a lack

# Summary of findings

of evidence to show how the action plan was being updated with their progress in meeting the requirements of the Infection Prevention and Control (IPC) audit.

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice had identified 339 (3%) of the patient list as carers and signposted them to local services offering support and guidance.
- Staff stated they felt respected, supported and valued.
- The practice listened and acted on issues raised by the patient participation group.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Document the outcome of fire drills.
- Record and act on verbal complaints received about the service.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

| | |
|---|---|
| **Older people** | **Requires improvement** |
| **People with long term conditions** | **Requires improvement** |
| **Families, children and young people** | **Requires improvement** |
| **Working age people (including those recently retired and students)** | **Requires improvement** |
| **People whose circumstances may make them vulnerable** | **Requires improvement** |
| **People experiencing poor mental health (including people with dementia)** | **Requires improvement** |

# Dr Guindy and Partners (also known as Orchard Surgery)

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist advisor, and a practice manager advisor and a second CQC inspector.

## Background to Dr Guindy and Partners (also known as Orchard Surgery)

Dr Guindy and Partners (also known as Orchard Surgery) is located in Norton In The Moors, Stoke on Trent and delivers regulated activities from Orchard Surgery and its branch in Endon (Endon Surgery). We carried out a comprehensive inspection of Orchard Surgery and also visited the branch as part of this inspection. The practice is part of the NHS Stoke on Trent Clinical Commissioning Group.

The practice is registered with the Care Quality Commission (CQC) as a partnership provider and holds a General Medical Services (GMS) contract with NHS England and provides a number of enhanced services to include minor surgery. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice treats patients of all ages and provides a range of medical services. There are currently around 10,670 registered patients at the practice.

The practice local area is in the fifth most deprived decile. The practice has 59% of patients with a long-standing health condition compared to the national average of 53%. The practice has a higher percentage of patients who are 65 years or above when compared to the CCG and national average.

The practice staffing comprises of:

- Four full-time partners (three males and one female).
- One salaried GP (male).
- One Nurse Practitioner.
- One Advanced Nurse Practitioner.
- Three practice nurses and two health care assistants.
- Three members of the management team.
- Four back office team.
- Ten reception staff.

The main surgery is open between 8am till 1pm and 2pm until 6pm Tuesday to Friday. The practice offers extended hours on a Monday where the practice is open between 8am and 1pm and 2pm until 7pm.

The branch surgery is open between 8am till 1pm and 2pm until 6pm Tuesday, Wednesday and Friday. The branch surgery is open between 8am and 1pm on a Thursday morning and is closed Thursday afternoon. The practice offers extended hours on a Monday at both surgeries until 7pm.

GP morning appointments run each day from 8.30am to 12 noon and from 2pm and 6pm, except for Monday where both practices offer appointments from 2pm to 7.15pm

# Detailed findings

The practice has opted out of providing out of hours cover for their patients. Vocare Ltd provides the practice out of hour's service and this service is accessed via calling 111.

Additional information about the practice is available on their website:

www.orchardsurgery.co.uk

Requires improvement

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as requires improvement for providing safe services.**

**The practice was rated as requires improvement for providing safe services because:**

- The provider was failing to ensure that care and treatment was provided in a safe way for patients.
- The systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff needed strengthening.

**Safety systems and processes**

The practice had some systems to keep patients safe and safeguarded from abuse.

- The practice had safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns and were able to share examples with us of the action they had taken to help safeguard patients receiving care and treatment.
- The practice had a chaperone policy, which indicated that only clinical staff acted as chaperones. However, we identified that receptionists occasionally acted as chaperones and had not received training for the role or were aware of where to stand during an intimate examination. They had however received DBS checks. Notices were displayed in consultation and clinical rooms advising patients that chaperones were available if required. Patients spoken with were aware of this service provided.
- There was an effective system to manage infection prevention and control. There was a designated infection prevention and control (IPC) clinical lead in place. Discussions with them demonstrated they had a clear understanding of their role and responsibilities. An IPC audit had been carried out in 2017 and an action plan had been developed to address the improvements identified. However, the action plan was not updated to reflect the actions taken. There were systems for safely managing healthcare waste.

**Risks to patients**

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff had received basic life support training. The practice had emergency equipment which included automated external defibrillators (AEDs), (which provides an electric shock to stabilise a life threatening heart rhythm) and oxygen with children and adult masks.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Sepsis guidelines were available in clinical rooms and an alert process appeared within their computer system. The practice had adult and paediatric pulse oximeters in each clinical room. Staff told us that they had also received training to identify signs of sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, the practice had recently added an advanced nurse practitioner and health care assistant to their team to develop the team's skill mix.

Requires improvement

# Are services safe?

**Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

**Safe and appropriate use of medicines**

The practice had some systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. However, not all of the suggested emergency medicines were held at the practice. Five emergency medicines including medicine for the treatment of croup in children were not stocked. The practice had not carried out a risk assessment to support the decision not to stock these items. After the inspection, the practice told us that following a clinical discussion, they had decided to stock two of the five suggested medicines. The practice did not routinely carry medicines in GP bags, but carried medicines as and when required to treat possible side effects of vaccinations when giving these in people's homes. A risk assessment had not been undertaken to identify the need for the practice to carry emergency medicines in GP bags. Practice nurses used Patient Group Directions (PGDs) to administer medicines. We noticed that the PGD's were in date, but we noted that on four PGD's the authorising GP had signed their name in advance of a named clinician being inputted. We also noted on two occasions signatures were not against a named clinician to authorise them to administer medicines. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. Processes were in place for handling repeat prescriptions which include high risk medicines.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

**Track record on safety**

- Records showed that the fire alarm was tested regularly. We were told that fire drills had been undertaken but there was no documented evidence available to support this.
- The practice ensured that the equipment were safe and maintained according to manufacturers' instructions.
- Some risk assessments were in place in relation to safety issues including fire risk assessment. Health and safety policies were available and recently updated. We noted that window blinds had loop cords attached to them; however there was no risk assessment in place to manage the risk to patients.
- At the time of the inspection, there was no asbestos assessment available for the practice. Following the inspection, the practice told us that they had reviewed their files and confirmed that an asbestos report was undertaken in October 2015 on the bungalow (used as an administration office). No record of any audits for either of the main or branch surgeries could be located. The practice told us that following the inspection they had instructed their estates colleagues to advise them on a local specialist company to undertake the surveys.
- At the previous inspection we made a good practice recommendation that the provider complete a legionella risk assessment. At this inspection we saw a full legionella risk assessment had been completed ten days prior to this inspection. Many immediate actions were required to be completed and an order had been placed to rectify some of the issues identified. The practice told us following the inspection that they were arranging a follow up with their estates department to take forward the recommendations made within the report.

Requires improvement

# Are services safe?

- The practice did not have certificates in place to show that electrical periodic inspection tests had been completed.

**Lessons learned and improvements made**

- The practice learned and made improvements when things went wrong.
- There was a system and procedure for recording and acting on significant events and incidents. There was a standard recording form available on the practice's computer system. Staff we spoke with told us they were encouraged to raise concerns and report incidents and near misses and demonstrated an understanding of the procedure. Staff were able to share an example of a recent significant event, the action taken and learning shared. Staff told us they were supported by managers when raising significant events.
- There were adequate systems for reviewing and investigating when things went wrong. The practice had recorded seven significant events in the last 12 months. Significant events were discussed at clinical meetings. The practice learned and shared lessons identified themes and took action to improve safety in the practice. For example, steps had been taken to alert staff when babies had reached the age for immunisations so that if no appointment had been made for them, the nurses would be alerted and would follow this up.
- There was not an effective system in place to log, review, discuss and act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety. The system for receiving and acting on safety alerts was inconsistent. For example the practice had undertaken a check to identify patients on a high dose of medicine used for nocturnal leg cramps. The practice however had not undertaken a check to identify women of childbearing age on a specific medicine in response to concerns raised within an alert. Staff were unable to demonstrate how other MHRA alerts had been acted on but told us that they worked with the CCG pharmacist who undertook some searches. There was no log kept of alerts coming into the practice nor was there evidence that the alerts were discussed within clinical meetings. We saw other examples where the practice had not received alerts including alerts relating to estates and facilities. For example, the practice had not received or acted on an alert which advised the discontinuation of 13 Amp electrical socket covers. We saw evidence that the practice still used socket covers at both surgeries.There was no risk assessment in place in relation to the continued use of these covers. Following the inspection, the practice had submitted comprehensive information outlining the action they had taken to check, record and act on alerts that affected patients.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as good for providing effective services overall and across all population groups.**

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice's daily quantity of Hypnotics per Specific Therapeutic group prescribed was slightly lower than the CCG and national average. The local and England averages were broadly 1% (for that therapeutic group) where the practice prescribed these drugs to 0.65% of patients within that therapeutic group.
- The practice was comparable to the Clinical Commissioning Group (CCG) and national averages for antibiotic prescribing. The number of items the practice prescribed was 1.05% compared with the CCG average of 1.18% and national average of 1%.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had set up an intranet page which contained links to NICE guidelines and included a bank of tutorials for their registrars to access.

Older people:

- The practice used the frailty index to identify older patients who were frail or vulnerable. They received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Falls risk assessments were completed by the practice and those at risk were referred to occupational therapy or the falls prevention services.
- Regular meetings with the integrated local care team (district nurses, social workers and care coordinators) were held to discuss frail and vulnerable patients' needs andinformation was shared to ensure safety, identify patient needs as well as ensure support for carers.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Patients over the age of 75 years had been identified and had a named GP.
- There is a named GP for each care home.
- The practice offered flexibility of appointments for patients to receive the flu vaccination. GPs also offered home visits to housebound patients or patients living in nursing homes in order for them to receive the flu vaccination. The percentage of patients over 65 years of age, who had received the flu vaccination was 77%. This was higher than the national average of 73%.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Data available showed that the practice scored well for their management of long-term conditions. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading in the last 12 months was 140/80 mmHg or less was 81%, which was in line with the CCG average of 80% and the national average of 78%. The practice exception reporting rate of 14% was higher than the CCG average of 8% and the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- The percentage of patients on the diabetes register, The practice exception reporting rate of 17% was higher than the CCG average of 11% and national average of 13%.
- The percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been

Good

# Are services effective?

## (for example, treatment is effective)

over a period of time was recorded as 87% compared with the CCG average of 77% and the national average of 80%. The practice exception reporting rate of 15% was higher than the CCG average of 9% and higher than the national average of 12%.

- 80% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma. This was slightly higher than the CCG average of 78% and the national average of 76%. The practice exception reporting rate of 4% was lower than the CCG average of 7% and the national average of 8%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to under two year olds were above the target percentage of 90% and the rate for five year olds ranged from 92% to 99%.
- Appointments were offered outside the school hours.
- Weekly antenatal clinics were held by appointment with the visiting community midwife.
- Family planning services were provided by the practice.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 81%, which was the same as the national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Data shared with us by the practice showed that 12% of the patients eligible for a NHS health check had received one. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- 60% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was higher than the CCG and national average of 54%.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 74 registered patients with a learning disability of which 69% had received an annual review.
- The practice had identified (3%) of the patient list as carers and signposted them to local services offering support and guidance.

People experiencing poor mental health (including people with dementia):

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was in line with the CCG average of 83% and the national average of 84%.The practice exception reporting rate of 6% which was the same as the CCG average and slightly lower than the national average of 7%.
- 94% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the CCG average of 89% and the national average of 90%.The practice exception reporting rate of 16% was higher than the CCG average of 10% and national average of 13%, meaning fewer patients were included.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 94% compared with the CCG average of 89% and the national average of 90%.

**Monitoring care and treatment**

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had undertaken a number of audits to review practice. For example the practice had carried out a mortality audit, which showed that most reviewed patients had received good standards of care.

The most recent published Quality Outcome Framework (QOF) results showed that the practice achieved 100% of the total number of points available which was above the clinical commissioning group (CCG) average and national

Good

# Are services effective?

## (for example, treatment is effective)

average of 97%. The overall exception reporting rate was 10%, which was the same as the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, one of the nurses was being supported to attend a degree level 12 week course at Keele University.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

**Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

**Helping patients to live healthier lives**

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. Pre-diabetic patients were given information and were monitored.

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness**,** respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs as recommended at the previous inspection. Signs were on display in the waiting rooms advising patients they could request a private room.
- All of the 15Care Quality Commission comment cards we received were mostly positive about the service experienced. Patients told us that staff were polite, kind and keen to meet all patients' needs and endeavoured to treat patients to the best of their ability. They told us staff took time to listen to them and were reassuring and thorough.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and twenty one surveys were sent out and 102 were returned. This represented about 1% of the practice population. The practice scored the same or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 86% of patients who responded said the GP gave them enough time, which was the same as the CCG and the national average
- 98% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average and national average of 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 85% and the national average of 86%.
- 97% of patients who responded said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 99% of patients who responded said the nurse gave them enough time compared with the CCG and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG and the national average of 97%.
- 97% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG and the national average of 91%.
- 89% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, care plans had been written in easy read format for patients with a learning disability. Where patientshad communication needs, these were added as alerts to their records. This alerted staff who needed additional support.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 339 patients as carers (3% of the practice list). Carers were also identified on care plans. Information leaflets were given to carers to enable them to access support and information was available on their website. End of life care plans were in place. Staff told us that if families had experienced

Good

# Are services caring?

bereavement, their usual GP contacted them. We were told that their approach would be individual to the patients' needs. Patient feedback was positive about the care they had received following the death of their loved one. Leaflets were available for patients experiencing bereavement and the practice website also signposted patients to information.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with or slightly higher than local and national averages:

- 87% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 79% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG and the national average of 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 91% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 87% and the national average of 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- A private area was available should a patient wish to discuss sensitive issues.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.**

**Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example online services such as repeat prescription requests, and advanced booking of appointments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations could be booked for patients unable to access either the practice within normal opening times.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Double appointments were offered at the request of patients or if clinicians felt they were necessary.
- Advice was available to patients and their relatives or carers via the daily nurse triage service.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a childwere offered a same day appointment when necessary.
- The premises was suitable for children, babies and breastfeeding mothers.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, a range of appointments were available each day including morning and afternoon appointments with the exception of a Thursday afternoon at the branch surgery. Extended hours service was offered on Monday evenings at either surgery.
- Internet access was offered to request repeat prescriptions and doctor appointments.
  A telephone triage service was available each work day between 8am and 11.30am. Emergency on the day appointments were available to patients triaged as requiring on the day appointments.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including people with a learning disability.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice was proactive in identifying carers and had identified 3% of the patient list and signposted them to local services offering support and guidance.
- The practice had a system in place for patients who were homeless or with no fixed abode.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Information relating to mental health awareness was available on the practice's website and within patient leaflets in the practice. The practice signposted patients to various services and support groups for information and support.
- The practice provided a room for a Healthy Minds counsellor to carry out their clinics.

**Timely access to the service**

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed CQC comment cards. Two hundred and twenty one surveys were sent out and 102 were returned. This represented about 1% of the practice population.

- 71% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 70% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 67% and the national average of 71%.
- 93% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 83% and the national average of 84%.
- 89% of patients who responded said their last appointment was convenient compared with the CCG and the national average of 81%.
- 79% of patients who responded described their experience of making an appointment as good compared with the CCG and the national average of 73%.
- 70% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG and the national average of 64%.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. There were signs up in the practice to advise patients how to raise concerns and information was within the practice leaflet. Reception staff had access to the complaints process and advised patients accordingly. Patients' feedback however highlighted that verbal complaints were not always responded to and acted upon. We were told that the practice did not record verbal complaints but would contact patients directly following receipt of a formal complaint.
- The complaint policy and procedures were in line with recognised guidance. Seventeen complaints had been received in the last year. We reviewed four complaints and found that a detailed log had been kept. The complaints were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends.

# Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Our findings

**We rated the practice as requires improvement for providing a well-led service.**

**The practice was rated as requires improvement for being well-led because:**

- Governance arrangements were not always operated effectively
- There was not always a clear and effective process for managing risks.

**Leadership capacity and capability**

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice had recruited an advanced nurse practitioner and a health care assistant to broaden the skill mix of the team and improve patient access to the service.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff we spoke with told us they felt well supported by the partners and practice manager. Staff had lead roles and were aware of their roles and responsibilities.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement. This was to provide safe, holistic and patient centred care and be aware of the characteristics, health and social needs of the communities they served. The practice strived to review, improve and innovate their services and care and develop, train and retain clinicians and staff.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. The mission statement was shared with patients within the patients charter, which was on display in the practice's waiting room.

**Culture**

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. Staff spoke with enthusiasm about their role in caring and supporting patients.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example staff had contacted patients regarding complaints discussion and resolution. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

**Governance arrangements**

# Are services well-led?

Requires improvement

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

There were governance systems and processes in place however, they did not always operate effectively and were inconsistent.

The practice had effective processes in place in a number of areas, for example:

- Staff were clear on their roles and accountabilities including in respect of safeguarding..

There were areas of governance that required strengthening, for example:

- Practice policies, procedures and activities did not always govern practice, for example we saw that staff did not work within the chaperone policy, not all staff who acted as a chaperone had completed appropriate training.
- There was a lack of recording of performance for example in meeting the requirements of the Infection Prevention and Control (IPC) audit.
- There was a lack of oversight to ensure PGD's were authorised and were appropriately signed.
- Verbal complaints were not always responded to and acted upon.

**Managing risks, issues and performance**

There was not always a clear and effective process for managing risks.

- The practice did not have adequate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, we found that the system in place for the actioning of patient safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) was not effective in managing risks to patients. However, information submitted following the inspectionshowed that the practice had taken the CQC feedbackseriously and had taken immediate steps to minimise further risk to patients.
- The practice had not assured themselves that procedures were always in place for monitoring and managing risks to patient and staff safety. For example, the practice did not have certificates in place to show that electrical periodic inspection tests had been completed and the risk of blind loops had not been assessed. There was a lack of risk assessments for keeping some of the recommended emergency drugs both in the practice and in doctors bags when out on home visits. There was also a lack of documented fire procedures as fire drills were not recorded.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. The practice shared their emergency policy with us.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

- The practice had an established patient participation group (PPG) which consisted of five members. They aimed to meet every two to three months. During the inspection we spoke with two members of the group. They told us they felt valued and that the practice listened and acted on issues they raised. For example,

# Are services well-led?

Requires improvement

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

the practice's opening hours were reviewed and changed to offer early morning appointments to working patients. The PPG was also involved in developing questionnaires to collect patient feedback.

- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The practice was part of the Keele University GP Research Network and participated in certain health projects.
- Staff knew about improvement methods and had the skills to use them.
- Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12 Safe care and treatment**<br>**How the regulation was not being met:**<br>The provider was failing to ensure that care and treatment was provided in a safe way for patients. In particular:<br>• The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: patient safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were not always acted on.<br>• The practice has not carried out a risk assessment to reflect the emergency medicines required in the practice for the range of treatments offered and the conditions treated. The practice had not carried out a risk assessment to reflect the decision not to carry emergency medicines in doctors bags.<br>• Some PGD's had not been appropriately signed.<br>This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 Good Governance**<br>**How the regulation was not met:** |

This section is primarily information for the provider

# Requirement notices

There were governance systems and processes in place however these were not always effective and compliant with the requirements of the fundamental standards of care. In particular:

- The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. In particular: the practice did not have certificates in place to show that electrical periodic inspection tests had been completed and the risk of blind loops had not been assessed. Asbestos assessments were not in place for the main surgery and the branch surgery. Fire drills were not recorded.
- Practice policies, procedures and activities did not always govern practice, for example we saw that staff did not work within the chaperone policy.
- There was a lack of recording of performance for example in meeting the requirements of the Infection Prevention and Control (IPC) audit.
- Verbal complaints were not always responded to and acted upon.

This was in breach of regulation 17 (1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.